

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07671

7692

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 9 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Route # 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hiram Middle Adams Last Adams		4. DATE OF DEATH Month July Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/15/1877
9. AGE (In years last birthday) 79 yes		IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min. 5	IF UNDER 24 HRS. Months 7 Days 9 Hours 15 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Adams		14. MOTHER'S MAIDEN NAME Belle Ober	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
20f. (City or town) -		(County) (State)	
21. I certify that I attended the deceased from Sept. 28 , 19 55 , to July 2 , 19 56 , that I last saw the deceased alive on July 2 , 19 56 , and that death occurred at 12:10PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/2/56 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/5/56	Washington	Shillock md
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Hillenbray, E. H. M. Hillenbray		24a. REC'D BY REGISTRAR 6	24b. REGISTRAR'S SIGNATURE 1956 Mary H. Holloway

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The text is mirrored and difficult to read.

BUREAU V. 2

JUL 6 1956

RECEIVED

7693

CERTIFICATE OF DEATH

07672

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23X2</u>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Armstrong</u> Middle Last				4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>1952</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20 - 1871</u>	
9. AGE (In years, last birthday) <u>81 3/23</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Co</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09947</u>			
17. INFORMANT <u>Mrs. Maggie Pettit</u> Address <u>Snow Hill, md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>420.0</u> DUE TO <u>Sanguine Barth lower extremities 3 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>360</u> (b) <u>Arteriosclerosis obliterans</u> (c) <u>Arteriosclerosis obliterans</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/28/52</u> to <u>7/13/52</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>7/13/52</u> , 19 <u>52</u> , and that death occurred at <u>3pm</u> , M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David G. Gihane</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>July 13, 1952</u>			
PHYSICIAN'S NAME (Type) <u>David G. Gihane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16/52</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Blum</u> ADDRESS <u>Snow Hill, md</u>				24a. REC'D BY REGISTRAR <u>JUL 16 1952</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mary H. Falloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

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CERTIFICATE OF DEATH

1956

BUREAU V. S.

JUL 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Willow St. (City Dog Pound)		d. STREET ADDRESS R.D. # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Dale Bailey		4. DATE OF DEATH July 27 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1888
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR 10 Months 20 Days	IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done, even if retired) Employee of Wicomico County and City of Salisbury		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Thomas Bailey		14. MOTHER'S MAIDEN NAME Annie Mae Trader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. W. Dale Bailey (Wife) Mrs. Laura A. Bailey (Wife)		Address R.D. # 2 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY 19 Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 30 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

JUL 30 1952

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7695

CERTIFICATE OF DEATH

Reg. Dist. No. 1170742
332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar Route # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last Barkley			4. DATE OF DEATH Month July Day 25 Year 19 56				
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1868		9. AGE (In years last birthday) yrs. 88 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archie Barkley				14. MOTHER'S MAIDEN NAME Ester Grames			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of right great toe						INTERVAL BETWEEN ONSET AND DEATH 5 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2 , 19 56 , to July 25 , 19 56 , that I last saw the deceased alive on July 25 , 19 56 , and that death occurred at 10:12PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE V. Juerman M.D. V. Juerman, M. D. 7/26/56 PHYSICIAN'S NAME (Type) V. Juerman, M. D. Deer's Head State Hospital Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-29-1956		22c. NAME OF CEMETERY OR CREMATORY Flower Hill Cemetery		22d. LOCATION (City, town, or county) (State) Eden, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Wilson ADDRESS Princess Anne, Md.				24a. REC'D BY REGISTRAR DATE 7-31-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

CERTIFICATE OF DEATH

Princess Anne, Md.

Princess Anne, Md.

BUREAU V. 2

AUG 1 1956

RECEIVED

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08776

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Salisbury</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>U S N A S Chincoteague</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>U S N A S Chincoteague</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Barnett</u>		4. DATE OF DEATH Month Day Year <u>7- 21 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-32</u>
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>23</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>U S N</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>U.S. Navy Records, Washington, D. C.</u>	
17. INFORMANT <u>U.S. Navy Records, Washington, D. C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO (b) <u>824X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>824X</u> DUE TO (b) <u>824X</u> DUE TO (c) <u>824X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Put head out of moving car and struck head on utility pole.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Put head out of moving car and struck head on utility pole.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>12:30 A. 7-21-56 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20f. (City or town) <u>Salisbury</u>		20g. (County) <u>Wicomico</u>	
20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-21-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Norfolk, Virginia</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Derry-Twiford Funeral Home, Norfolk, Va.</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		DATE <u>2-2-1956</u>	

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

BUREAU V. B.

AUG 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7697

CERTIFICATE OF DEATH

Reg. Dist. No.

8767532

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle GUNBY Last BELL		4. DATE OF DEATH Month 7 Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1878
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Sidney Bell		14. MOTHER'S MAIDEN NAME Elizabeth Gunby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-1124	
17. INFORMANT Mrs. Fred G. Bell, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 to 7/2 , 19 56 , that I last saw the deceased alive on 7/2 , 19 56 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED Dr. Fred R. Gramse			
ACTUAL SIGNATURE Dr. Fred R. Gramse M.D.		DATE SIGNED Salisbury, Md	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 South Division St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/56	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR 5-56 24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

CERTIFICATE OF DEATH

1027

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Date of Death		Time of Death		Place of Death		Physician		Hospital		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
John Doe		Male		45		1910		New York		New York		Heart Disease		Natural		Teacher		High School		Catholic		Married		July 5, 1956		10:00 AM		New York		Dr. Smith		St. John's		St. John's		July 6, 1956		11:00 AM		St. John's		July 6, 1956		11:00 AM	

RECEIVED
JUL 6 1956
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08778

Reg. Dist. No.

331

Item 9 FilmG202 8-28-56 et

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway</u>				d. STREET ADDRESS <u>USS Darby DE 218 Convoy Escort</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u>		First <u>George</u> Middle <u>W.</u> Last <u>Benjamin</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>21</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1934</u>		9. AGE (In years last birthday) <u>22 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <u>yes</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>U.S. Navy Records, Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushed chest</u> DUE TO <u>816x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car that struck the back of stopped bus.</u>							
20c. TIME OF INJURY Month, Day, Year <u>4:45 p.m. 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>7-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY 			
22d. LOCATION (City, town, or county) <u>Norfolk, Virginia</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Derry-Twiford Funeral Home, Norfolk, Va</u>				24a. REC'D BY REGISTRAR <u>AUG 22 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>				 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 22 1956

BUREAU V. 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

CERTIFICATE OF DEATH

17677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 1 1/2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS RT. #3			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM EDWARD BROWN				4. DATE OF DEATH Month Day Year JULY 17 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1883		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. 3 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware	
13. FATHER'S NAME James Benjamin Brown				14. MOTHER'S MAIDEN NAME Sarah Warrington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mr. Otis C. Brown (Brother)			
17. INFORMANT Mr. Otis C. Brown (Brother)				Address Glen St. Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding on both right & left sides of brain. (c) Arteriosclerosis of vessels & hypertension.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17/56 , 19 56 , that I last saw the deceased alive on 7/17/56 , 19 56 , and that death occurred at 6:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 605 Division St. Salisbury, Maryland DATE SIGNED July 17 1956							
ACTUAL SIGNATURE Carrie Hearne				PHYSICIAN'S NAME (Type) Dr. Carrie Hearne M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 19, 1956				22b. DATE THEREOF July 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 23 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
James Earl Ray		July 19, 1968	
Age		39	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		None	
Cause of Death		Suicide	
Place of Death		Baltimore, Maryland	
Physician		Dr. J. Edgar Hoover	
Manner of Death		Suicide	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		July 23, 1968	

BUREAU V. 2

JUL 23 1968

RECEIVED

RECEIVED JUL 23 1968
BUREAU OF RECORDS & COMMUNICATIONS
U.S. DEPARTMENT OF JUSTICE

7700

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 15 Wicomico ST.							
3. NAME OF DECEASED (Type or print) WILLIAM Charles BUCKMAN				4. DATE OF DEATH July 26 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27th 1894	
9. AGE (In years (at birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restuarant Owner		10b. KIND OF BUSINESS OR INDUSTRY Foods	
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Buckman		14. MOTHER'S MAIDEN NAME Virginia Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Gladys Buckman		15 Wicomico Street Ocean City, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, left lung 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated Appendix peritonitis DUE TO (c) 6 days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-20, 1956 to 7-26, 1956 that I last saw the deceased alive on 7-26, 1956 , and that death occurred at 2:50 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE William H. Fisher Jr. M.D. Salisbury, Ind.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) William H. Fisher Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Lamoreaux				ADDRESS 4510 Liberty Heights Avenue		24a. REC'D BY REGISTRAR 30 1956	
				24b. REGISTRAR'S SIGNATURE Mary K. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Jackson		Male		45		1890		Maryland		Baltimore, Md.		Heart Disease		July 20, 1933		10:00 AM		City of Baltimore		J. H. Smith		J. H. Smith	
Occupation		Married		Single		Widowed		Divorced		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Jackson		Male		45		1890		Maryland		Baltimore, Md.		Heart Disease		July 20, 1933		10:00 AM		City of Baltimore		J. H. Smith		J. H. Smith	
Occupation		Married		Single		Widowed		Divorced		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Jackson		Male		45		1890		Maryland		Baltimore, Md.		Heart Disease		July 20, 1933		10:00 AM		City of Baltimore		J. H. Smith		J. H. Smith	
Occupation		Married		Single		Widowed		Divorced		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

RECEIVED
JUL 30 1933
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7701

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

076292

Item 9, Film G200, 7/31/56 bh

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wicomico</u> b. COUNTY <u>Salisbury</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>7</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home of neighbor-Snow Hill Road</u>				d. STREET ADDRESS <u>Snow Hill Road, Salisbury, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lemuel</u> Middle <u>Melvin</u> Last <u>Cartwright</u>				4. DATE OF DEATH Month <u>7-</u> Day <u>8-</u> Year <u>1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>			
9. AGE (In years to birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u>		IF UNDER 24 HRS. Hours <u>?</u> Min. <u>?</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>9</u>		17. INFORMANT Address <u>?</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage and laceration of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>?</u> DUE TO (c) <u>?</u> cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit several times with an axe during fight with neighbor.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11 P</u> o. m. <u>7-8-</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-17-56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-18-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burials Care</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury</u> <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boeken M. West</u>				ADDRESS <u>?</u>		24a. REC'D BY REGISTRAR DATE <u>7-23-56</u>			
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
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46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
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94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

JUL 25 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07680

7738

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 Delmar Road				d. STREET ADDRESS R.D.# 3 Delmar Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle LOUIS Last CONWAY				4. DATE OF DEATH Month JULY Day 4 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1885		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming (Retired)			10b. KIND OF BUSINESS OR INDUSTRY on Farm		11. BIRTHPLACE (State or foreign country) R.D.# Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Conway				14. MOTHER'S MAIDEN NAME (Unk)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Cecie L. Conway (Wife) Address R.D.# 3 Delmar Road Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 20, 1956 to July 4, 1956 , that I last saw the deceased alive on June 20, 1956 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 334 Camden Ave. (Office) DATE SIGNED July 5 1956							
ACTUAL SIGNATURE William D. Gray M.D.				334 Camden Ave. (Office) July 5 1956			
PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. S.

1956 6

RECEIVED

7702

CERTIFICATE OF DEATH

Reg. Dist. No. 324

07681

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Int. Hearman Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Conbin</u>				4. DATE OF DEATH Month Day Year <u>July 15-1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14-1956</u>	
9. AGE (In years, last birthday) <u>8</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Arabella Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/15/56</u> , 19 <u>56</u> , to <u>7/15/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/15/56</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris L. Lintkin</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury</u>				24a. REC'D BY REGISTRAR <u>DATE 7-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate information, including fields for name, date, and cause of death. The form is partially filled out with handwritten text.

NAME: *John Doe*
DATE: *July 14, 1956*
CAUSE OF DEATH: *Heart Disease*

RECEIVED
JUL 18 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7703

CERTIFICATE OF DEATH

07682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELEWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>505 JEWEL ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ARTHUR CORDREY</u>		4. DATE OF DEATH Month Day Year <u>JULY 4 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7/1887</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		9b. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Delmar, Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Cordrey</u>		14. MOTHER'S MAIDEN NAME <u>Sarina Hitchens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-9136</u>	
17. INFORMANT <u>Gellie Cordrey</u>		Address <u>Delmar, Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic nephritis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>56</u> to <u>7-4</u> , 19 <u>56</u> and I last saw the deceased alive on <u>7-4-56</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 7-4-56</u>	
ACTUAL SIGNATURE <u>W. R. [Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>W. R. [Signature]</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-56</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. [Signature]</u>		24. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
ADDRESS <u>Delmar, Del</u>		DATE <u>9 1956</u>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DATE OF INTERMENT [Faint text]</p>		<p>PLACE OF INTERMENT [Faint text]</p>	
<p>SIGNATURE OF DECEASED [Faint text]</p>		<p>SIGNATURE OF WITNESS [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>	

BUREAU V. R.

JUL 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7704

CERTIFICATE OF DEATH

Reg. Dist. No.

07683

331

7. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>109 B. COLLINS ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>COSTEN</u> Last <u>COSTEN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15-1886</u>
9a. AGE (In years last birthday) <u>70-4-10</u>		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brown Canning Co</u>	
11. BIRTH PLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Costen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-5568</u>	
17. INFORMANT <u>Mrs. Magdalen G. Jones</u>		Address <u>22 Cedar Rd, Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 340.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumococcal meningitis</u> (c) <u>2 1/2 wks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>56</u> , to <u>7/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/26</u> , 19 <u>56</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u>		ADDRESS (Street, city or town, state) <u>321 S. DIV. ST., SALISBURY, MD</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Sumner</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
DATE <u>JUL 30 1956</u>			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF BIRTH <i>Jan 15 1911</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>DATE OF DEATH <i>Jul 10 1956</i></p>		<p>PLACE OF DEATH <i>Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>INTERPRETER'S SIGNATURE <i>[Signature]</i></p>		<p>DECEASED'S SIGNATURE <i>[Signature]</i></p>	
<p>WITNESSES' SIGNATURES <i>[Signatures]</i></p>		<p>REGISTRAR'S SIGNATURE <i>[Signature]</i></p>	

RECEIVED
JUL 30 1956
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7705

CERTIFICATE OF DEATH

17684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>7 Philadelphia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stella</u> First <u>Cox</u> Middle <u>Cox</u> Last				4. DATE OF DEATH <u>July 2</u> 19 <u>56</u> Month <u>July</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26, 1897</u> 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES SIMPSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN WONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>DAVID COX OCEAN CITY MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>July 2, 1956</u> Hour <u>—</u> a.m. <u>—</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 2, 1956</u> to <u>July 2, 1956</u> , that I last saw the deceased alive on <u>July 2, 1956</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>David J. Gutman M.D.</u>							
PHYSICIAN'S NAME (Type) <u>David J. Gutman M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Salisbury</u> ADDRESS				24a. REC'D BY REGISTRAR <u>6</u> 1956		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

Reg. No. 100

NAME OF DECEASED CHARLES SIMPSON		AGE 35		SEX Male	
DATE OF DEATH July 3, 1956		PLACE OF DEATH Home		CITY Baltimore	
CITY OF DEATH Baltimore		STATE OF DEATH Maryland		COUNTY Baltimore	
MARRIED Yes		OCCUPATION None		EDUCATION High School	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF WITNESSES [Signature]	
DATE OF BURIAL July 5, 1956		PLACE OF BURIAL Cemetery		CITY OF BURIAL Baltimore	
STATE OF BURIAL Maryland		COUNTY OF BURIAL Baltimore		SIGNATURE OF MINISTER [Signature]	
SIGNATURE OF MINISTER [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF NEXT OF KIN [Signature]	
SIGNATURE OF WITNESSES [Signature]		SIGNATURE OF WITNESSES [Signature]		SIGNATURE OF WITNESSES [Signature]	

BUREAU V. 5

JUL 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07685

7706

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 839 Cooper St			
3. NAME OF DECEASED (Type or print) First THOMAS Middle FRANCIS Last CROCKETT				4. DATE OF DEATH Month July Day 30 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1899	9. AGE (In years last birthday) yrs. 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator-(Employee of Road Bldg Co.)		11. BIRTHPLACE (State or foreign country) Somerset County, Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator-(Employee of Road Bldg Co.)				10b. KIND OF BUSINESS OR INDUSTRY Somerset County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Samuel Crockett				14. MOTHER'S MAIDEN NAME Ida Dize			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Edna M. Crockett (Wife) Address 839 Cooper St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7/30 , 19____, and that death occurred at 7:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Maryland DATE SIGNED _____							
ACTUAL SIGNATURE A. C. Mitchell M.D.							
PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell M.D. July 31, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 2, 1956	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memorial Gardens		22d. LOCATION (City, town, or county) (State) Hebron, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD			24a. REC'D BY REGISTRAR AUG 2 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway		

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE		MARRIAGE	
John Doe		John Doe		John Doe	
DATE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
July 1, 1956		Baltimore, Md.		Baltimore, Md.	
AGE		SEX		RACE	
45		Male		White	
DATE OF BIRTH		PLACE OF BIRTH		PLACE OF BIRTH	
July 1, 1911		Baltimore, Md.		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Heart Disease		Natural		Natural	
DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
DATE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION	
July 1, 1956		Baltimore, Md.		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
John Doe		John Doe		John Doe	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
July 1, 1956		July 1, 1956		July 1, 1956	

BUREAU V. 3

AUG 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7707

CERTIFICATE OF DEATH

Reg. Dist. No. 07686

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emma Middle Virginia Last Crouch		4. DATE OF DEATH Month July Day 23 Year 19 56					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1871	9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Purnell Reddish				14. MOTHER'S MAIDEN NAME Maria Jane Farlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records Mrs. James E. Smith (Daughter) Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25 , 19 56 , to July 23 , 19 56 , that I last saw the deceased alive on July 23 , 19 56 , and that death occurred at 11:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Deer's Head State Hospital				DATE SIGNED 7/24/56	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1956		22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. RECEIVED BY REGISTRAR DATE 25 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloways	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration		14. Place of registration	
JAMES EARL RAY		Male		35		April 22, 1928		Memphis, Tennessee		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Shot		Homicide		JAMES EARL RAY		JAMES EARL RAY		April 4, 1968		Memphis, Tennessee	
15. Name of informant		16. Relationship		17. Occupation		18. Education		19. Marital status		20. Date of marriage		21. Date of last contact		22. Date of last contact		23. Date of last contact		24. Date of last contact		25. Date of last contact		26. Date of last contact		27. Date of last contact		28. Date of last contact	
JAMES EARL RAY		Son		None		High School		Single		None		None		None		None		None		None		None		None		None	
19. Marital status		20. Date of marriage		21. Date of last contact		22. Date of last contact		23. Date of last contact		24. Date of last contact		25. Date of last contact		26. Date of last contact		27. Date of last contact		28. Date of last contact		29. Date of last contact		30. Date of last contact		31. Date of last contact		32. Date of last contact	
Single		None		None		None		None		None		None		None		None		None		None		None		None		None	
33. Name of informant		34. Relationship		35. Occupation		36. Education		37. Marital status		38. Date of marriage		39. Date of last contact		40. Date of last contact		41. Date of last contact		42. Date of last contact		43. Date of last contact		44. Date of last contact		45. Date of last contact		46. Date of last contact	
JAMES EARL RAY		Son		None		High School		Single		None		None		None		None		None		None		None		None		None	
47. Name of informant		48. Relationship		49. Occupation		50. Education		51. Marital status		52. Date of marriage		53. Date of last contact		54. Date of last contact		55. Date of last contact		56. Date of last contact		57. Date of last contact		58. Date of last contact		59. Date of last contact		60. Date of last contact	
JAMES EARL RAY		Son		None		High School		Single		None		None		None		None		None		None		None		None		None	

BUREAU V. 2

JUL 25 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07687

7739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		d. STREET ADDRESS In Village	
3. NAME OF DECEASED (Type or print) First MARION Middle C. Last CROUCH		4. DATE OF DEATH Month JULY Day 19th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1914
9. AGE (In years last birthday) yrs. 41		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man-Wicomico County Road Dept.		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William C. Crouch		14. MOTHER'S MAIDEN NAME Edna Pusey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Vivian Crouch (Wife)		Address Parsonsbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 54 to July 19, 1956 , that I last saw the deceased alive on July 18, 1956 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Earl Beardsley		DATE SIGNED July 20 1956	
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley M.D.		ADDRESS (Street, city or town, state) Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 23 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

BUREAU V. 3

JUL 23 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

87688

7708

CERTIFICATE OF DEATH

Reg. Dist. No.

382

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Full name, block and admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>RR #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Senora</u> Middle <u>Dashie</u> Last <u>II</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Achie Barkley</u>				14. MOTHER'S MAIDEN NAME <u>Esther Grames</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>no no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Archie Dashiell Eden, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Intracerebral Hemorrhage</u> <u>904.0</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Falls - due to dizziness</u> (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell backward striking occiput</u>					
20c. TIME OF INJURY Month, Day, Year <u>9:30 a.m. 7-8-1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Eden (Md) Somerset Md</u>	
21. I certify that I attended the deceased from <u>July 8, 1956</u> , to <u>July 10, 1956</u> , that I last saw the deceased alive on <u>July 10, 1956</u> , and that death occurred at <u>9:50 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Semblly (G. Herbert Semblly)</u>				DATE SIGNED <u>July 12, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eden, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lester R. Nelson</u>				ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR <u>7-18-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

22

JUL 19 1956

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

7740

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		d. STREET ADDRESS In Village	
3. NAME OF DECEASED (Type or print) First HERMAN Middle ELLIOTT Last ELLIOTT		4. DATE OF DEATH Month JULY Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith Shop	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Asbury Elliott		14. MOTHER'S MAIDEN NAME Laura Perdue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Carrie H. Elliott (Wife)		Address Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 241X DUE TO Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stenosis of bicuspid with atherosclerosis (report of V.A. Hoff, Washington 7-3)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 36	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to day of death , that I last saw the deceased alive on 7-23-56 , 19____, and that death occurred at 7:03 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Lewis		ADDRESS (Street, city or town, state) DATE SIGNED July 24th, 1956	
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis M.D. Willards, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1956	
22c. NAME OF CEMETERY OR CREMATORY Pittsville, Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR 25 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

7709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10 mo. 22 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 432 E. Church St.	
3. NAME OF DECEASED (Type or print) First Sallie Middle Ellen Last Ellis		4. DATE OF DEATH Month July Day 10 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1867
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) White Haven, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Levin Fletcher	
14. MOTHER'S MAIDEN NAME Jane Brewington Fletcher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records & Miss Lillian Ellis (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reactivated pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from August 18 19 55 , to July 10, 19 56 , that I last saw the deceased alive on July 10, 19 56 , and that death occurred at 12:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve, M. D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland	
DATE SIGNED 7/10/56		22. LOCATION (City, town, or county) (State) Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR July 12 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1234 Main St.		Teacher		Heart Disease		3 weeks		July 10, 1956		New York		New York		New York	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		MARRIAGE		MARRIAGE	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		High School		Roman Catholic		Married		Married	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
July 10, 1956		New York		New York		New York		July 10, 1956		New York		New York		New York	

BUREAU V. S.

JUL 12 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07691

7710 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 Wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>		d. STREET ADDRESS <u>Quantico</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>C.</u> Last <u>Freeny</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mardela, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Twilley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Flora Freeny, Quantico, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Intestinal Obstruction + Perforation</u> DUE TO (c) <u>Adenocarcinoma Rt. Colon - droppable</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>Unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8, 1956</u> , to <u>July 20, 1956</u> , that I lost saw the deceased olive on <u>July 20, 1956</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Long</u> M.D.		ADDRESS (Street, city or town, state) <u>Med. Center Salisbury Blvd. Salisbury 7/20/56 Md.</u>	
DATE SIGNED			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Quantico Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>	
24a. REC'D BY REGISTRAR <u>8-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

AUG 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 4,9 FilmG201 8-17-56 et

08789

CERTIFICATE OF DEATH

7711

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>md</u> CITY OR TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gen Sen Hosp</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY OR TOWN <u>Salisbury Md</u> STREET ADDRESS <u>713 West Ches Ave</u>				
3. NAME OF DECEASED (Type or Print) <u>Florence</u> (First) <u>Barett</u> (Middle) <u>Barett</u> (Last)				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>28</u> (Year) <u>1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Approx.</u> <u>18</u> yrs.	9. AGE last birthday IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Fla</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Gray</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Mcray</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>221-10-7011</u>		17. INFORMANT & ADDRESS <u>James Barett</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 322. IMMEDIATE CAUSE (A) <u>Oedema of Brain</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Over-indulgence in Alcohol</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>July 28, 1956</u> , to <u>July 28, 1956</u> that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.								
SIGNATURE <u>William D. Hearse</u>				ADDRESS (Street, city, town, state) <u>M.D. 226 North Davis St Salisbury, Md</u>		DATE SIGNED <u>8/1/56</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Shreen Acres</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>		
24. REC'D BY REGISTRAR <u>8-13-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		ADDRESS		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7712

CERTIFICATE OF DEATH

Reg. Dist. No.

07692

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP</u>		d. STREET ADDRESS <u>415 WALNUT</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>L. GILLESPIE</u> Middle <u>L. GILLESPIE</u> Last		4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 7 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>ONLY VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>EDWARD A. BELOTE</u>		14. MOTHER'S MAIDEN NAME <u>ANN HARRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS KENNETH E. JORDAN</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>myocardial</u> WASHIN INTERVAL BETWEEN ONSET AND DEATH, <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>56</u> , to <u>7/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/5</u> , 19 <u>56</u> , and that death occurred at <u>7/5</u> , 19 <u>56</u> , M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>July 7, 1956</u>			
ACTUAL SIGNATURE <u>David J. Silvers</u> M.D.		DATE SIGNED <u>July 7, 1956</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 8 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKSLEY SEM</u>		22d. LOCATION (City, town, or county) (State) <u>PARKSLEY VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 12 1956</u>	
ADDRESS <u>Pocomoke Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Kolloway</u>	

JUL 12 1956

RECEIVED

7713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 Washington St.				d. STREET ADDRESS 406 Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ADA Middle Last GORDY		4. DATE OF DEATH Month July Day 27 Year 1956		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1893		9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months 0 Days 11 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wicomico County Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Watson LeCates				14. MOTHER'S MAIDEN NAME Margaret P. Calloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Byrl Waller (Sister) R.D. # 2 Salisbury Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193X generalized sarcomatosis DUE TO Sarcoma of spinal cord Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mos (c) 3 mos						INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to July , 19 56 , that I last saw the deceased alive on 7/27 , 19 56 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. (Office) DATE SIGNED July 28 1956							
ACTUAL SIGNATURE Harry Mattox		M.D. Camden Ave. (Office)		DATE SIGNED July 28 1956			
PHYSICIAN'S NAME (Type) Dr. Harry Mattox		M.D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 30 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

7714

CERTIFICATE OF DEATH

Reg. Dist. No.

17694
337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>5yr. 7mo. 25hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen, Maryland</u>	
d. STREET ADDRESS <u>unk</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>—</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Green</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>arteriosclerosis gen.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>< 160</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332x</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. <u>—</u> p. <u>—</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25</u> , 19 <u>51</u> , to <u>July 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>56</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. V. Maldve</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>7-29-56</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Aug 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>W. H. Polary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barring</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>	
ADDRESS <u>Aberdeen Md.</u>		DATE <u>AUG 3 1956</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF CHURCH CLERK</p>		<p>19. SIGNATURE OF BURIAL SOCIETY</p>		<p>20. SIGNATURE OF FUNERAL HOME</p>	
<p>21. SIGNATURE OF CORONER</p>		<p>22. SIGNATURE OF JURY</p>		<p>23. SIGNATURE OF JUDGE</p>		<p>24. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>25. SIGNATURE OF STATE ATTORNEY</p>		<p>26. SIGNATURE OF ATTORNEY GENERAL</p>		<p>27. SIGNATURE OF COMMISSIONER OF HEALTH</p>		<p>28. SIGNATURE OF SECRETARY OF HEALTH</p>	
<p>29. SIGNATURE OF ASSISTANT SECRETARY</p>		<p>30. SIGNATURE OF CHIEF CLERK</p>		<p>31. SIGNATURE OF CLERK</p>		<p>32. SIGNATURE OF CLERK</p>	
<p>33. SIGNATURE OF CLERK</p>		<p>34. SIGNATURE OF CLERK</p>		<p>35. SIGNATURE OF CLERK</p>		<p>36. SIGNATURE OF CLERK</p>	
<p>37. SIGNATURE OF CLERK</p>		<p>38. SIGNATURE OF CLERK</p>		<p>39. SIGNATURE OF CLERK</p>		<p>40. SIGNATURE OF CLERK</p>	
<p>41. SIGNATURE OF CLERK</p>		<p>42. SIGNATURE OF CLERK</p>		<p>43. SIGNATURE OF CLERK</p>		<p>44. SIGNATURE OF CLERK</p>	
<p>45. SIGNATURE OF CLERK</p>		<p>46. SIGNATURE OF CLERK</p>		<p>47. SIGNATURE OF CLERK</p>		<p>48. SIGNATURE OF CLERK</p>	
<p>49. SIGNATURE OF CLERK</p>		<p>50. SIGNATURE OF CLERK</p>		<p>51. SIGNATURE OF CLERK</p>		<p>52. SIGNATURE OF CLERK</p>	
<p>53. SIGNATURE OF CLERK</p>		<p>54. SIGNATURE OF CLERK</p>		<p>55. SIGNATURE OF CLERK</p>		<p>56. SIGNATURE OF CLERK</p>	
<p>57. SIGNATURE OF CLERK</p>		<p>58. SIGNATURE OF CLERK</p>		<p>59. SIGNATURE OF CLERK</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF CLERK</p>		<p>62. SIGNATURE OF CLERK</p>		<p>63. SIGNATURE OF CLERK</p>		<p>64. SIGNATURE OF CLERK</p>	
<p>65. SIGNATURE OF CLERK</p>		<p>66. SIGNATURE OF CLERK</p>		<p>67. SIGNATURE OF CLERK</p>		<p>68. SIGNATURE OF CLERK</p>	
<p>69. SIGNATURE OF CLERK</p>		<p>70. SIGNATURE OF CLERK</p>		<p>71. SIGNATURE OF CLERK</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF CLERK</p>		<p>74. SIGNATURE OF CLERK</p>		<p>75. SIGNATURE OF CLERK</p>		<p>76. SIGNATURE OF CLERK</p>	
<p>77. SIGNATURE OF CLERK</p>		<p>78. SIGNATURE OF CLERK</p>		<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF CLERK</p>	
<p>81. SIGNATURE OF CLERK</p>		<p>82. SIGNATURE OF CLERK</p>		<p>83. SIGNATURE OF CLERK</p>		<p>84. SIGNATURE OF CLERK</p>	
<p>85. SIGNATURE OF CLERK</p>		<p>86. SIGNATURE OF CLERK</p>		<p>87. SIGNATURE OF CLERK</p>		<p>88. SIGNATURE OF CLERK</p>	
<p>89. SIGNATURE OF CLERK</p>		<p>90. SIGNATURE OF CLERK</p>		<p>91. SIGNATURE OF CLERK</p>		<p>92. SIGNATURE OF CLERK</p>	
<p>93. SIGNATURE OF CLERK</p>		<p>94. SIGNATURE OF CLERK</p>		<p>95. SIGNATURE OF CLERK</p>		<p>96. SIGNATURE OF CLERK</p>	
<p>97. SIGNATURE OF CLERK</p>		<p>98. SIGNATURE OF CLERK</p>		<p>99. SIGNATURE OF CLERK</p>		<p>100. SIGNATURE OF CLERK</p>	

BUREAU V. S.

AUG 3 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 TOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07695

7715 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 wks</u>		TOWN <u>Berlin, Rt #2 Md</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>707 North Westover Dr.</u>				STREET ADDRESS (If rural give location) <u>Route # 22</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ella Mae Hall</u>				<u>7 15 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FM</u>	<u>AA</u>	<u>Married</u>	<u>Sept 15, 1926</u>	<u>29</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Berlin, Md.</u>		<u>U S A</u>	
13. FATHER'S NAME <u>Spencer Briddell</u>				14. MOTHER'S MAIDEN NAME <u>Ella Fasset</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>219 14 3446</u>		<u>Charles Hall, Berlin, Md Rt #2</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4/6X</u>				<u>Myocardial Insufficiency</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Rheumatic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 8, 56</u> , 19 <u>56</u> , to <u>July 15, 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 13, 56</u> , 19 <u>56</u> , and that death occurred at <u>Salisbury Md</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>July 17, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-21-56</u>		<u>Showell</u>		<u>Showell, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JUL 20 1956</u>		<u>Mary H. Holloway</u>		<u>J F. Stewart Funeral Home</u>		<u>Salisbury, Md.</u>	

A34

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Cause of Death: _____

8. Place of Death: _____

9. Signature of Physician: _____

10. Signature of Registrar: _____

11. Signature of Coroner: _____

12. Signature of Medical Examiner: _____

13. Signature of Health Officer: _____

14. Signature of County Clerk: _____

15. Signature of State Registrar: _____

16. Signature of State Health Officer: _____

17. Signature of State Coroner: _____

18. Signature of State Medical Examiner: _____

19. Signature of State Health Officer: _____

20. Signature of State Registrar: _____

21. Signature of State Coroner: _____

22. Signature of State Medical Examiner: _____

23. Signature of State Health Officer: _____

24. Signature of State Registrar: _____

25. Signature of State Coroner: _____

26. Signature of State Medical Examiner: _____

27. Signature of State Health Officer: _____

28. Signature of State Registrar: _____

29. Signature of State Coroner: _____

30. Signature of State Medical Examiner: _____

31. Signature of State Health Officer: _____

32. Signature of State Registrar: _____

33. Signature of State Coroner: _____

34. Signature of State Medical Examiner: _____

35. Signature of State Health Officer: _____

36. Signature of State Registrar: _____

37. Signature of State Coroner: _____

38. Signature of State Medical Examiner: _____

39. Signature of State Health Officer: _____

40. Signature of State Registrar: _____

41. Signature of State Coroner: _____

42. Signature of State Medical Examiner: _____

43. Signature of State Health Officer: _____

44. Signature of State Registrar: _____

45. Signature of State Coroner: _____

46. Signature of State Medical Examiner: _____

47. Signature of State Health Officer: _____

48. Signature of State Registrar: _____

49. Signature of State Coroner: _____

50. Signature of State Medical Examiner: _____

51. Signature of State Health Officer: _____

52. Signature of State Registrar: _____

53. Signature of State Coroner: _____

54. Signature of State Medical Examiner: _____

55. Signature of State Health Officer: _____

56. Signature of State Registrar: _____

57. Signature of State Coroner: _____

58. Signature of State Medical Examiner: _____

BUREAU V. S.

JUL 20 1956

RECEIVED

Handwritten signature

BURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07697

7716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle L. Last Harkins				4. DATE OF DEATH Month July Day 3 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/17/1872	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Forest Hill, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph Harkins				14. MOTHER'S MAIDEN NAME Lourenna Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with 422.1 DUE TO aortic sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis, chronic				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) (County) (State) -							
21. I certify that I attended the deceased from May 21 , 19 56 , to July 3 , 19 56 , that I last saw the deceased alive on July 3 , 19 56 , and that death occurred at 9 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/3/56							
ACTUAL SIGNATURE J. Juerman				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 5/1956		22c. NAME OF CEMETERY OR CREMATORY Deer's Head State Hospital		22d. LOCATION (City, town, or county) (State) Chestnut Hill Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Foster				ADDRESS Bel Air Md		24a. REC'D BY REGISTRAR DATE JUL 6 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		MEMPHIS		TENNESSEE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		POST-MORTEM		SIGNATURE OF PHYSICIAN	
JULY 6, 1968		MEMPHIS		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		ONE WEEK		HOSPITAL		NO		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. 5

JUL 6 1968

RECEIVED

James Earl Ray
July 6, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7717

CERTIFICATE OF DEATH

07698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Union Ave				d. STREET ADDRESS 206 Union Ave			
3. NAME OF DECEASED (Type or print) First ALLIE Middle HEARN Last HEARN				4. DATE OF DEATH Month JULY Day 17 th Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 3 Days 5 Hours Min. 	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R. D. # Parsonsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John James Perdue				14. MOTHER'S MAIDEN NAME Hester Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Stella H. Brittingham (Daughter) Address 206 Union Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17/56 , to 7/17 , 19 56 , that I last saw the deceased alive on 7/17/56 , 19 , and that death occurred at 7:50 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 402 S. Division St (Office) DATE SIGNED July 17 1956							
ACTUAL SIGNATURE Fred R. Gramse M.D.				PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 23 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7718

CERTIFICATE OF DEATH

Reg. Dist. No.

07699

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Hill Pr. Sanitarium</u>				d. STREET ADDRESS <u>304 William St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>ALVION</u> Last <u>HEARN</u>				4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1870</u>	
9. AGE (In years last birthday) yrs. <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas S. Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jane Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-12-1392</u>		17. INFORMANT <u>Mrs. Ernest A. Hearn</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelo-nephritis</u> DUE TO (c) <u>Benign hypertrophy of the prostate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>6 weeks</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-22-56</u> , 19 <u>56</u> , to <u>7-27-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-27-56</u> , 19 <u>56</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>407 Camden Ave. Salisbury, Md.</u> DATE SIGNED <u>7-30-56</u>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. <u>407 Camden Ave. Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/30/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burke C. Neill</u>				ADDRESS <u>Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>7-31-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

CERTIFICATE OF DEATH

1713

NAME OF DECEASED Thomas A. Jones		SEX Male		AGE 45	
DATE OF DEATH August 1, 1956		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		MEDICAL HISTORY Hypertension	
OCCUPATION Salesman		EDUCATION High School		RELIGION Catholic	
BIRTH DATE March 15, 1911		BIRTH PLACE Baltimore, Md.		MARITAL STATUS Married	
NAME OF WIFE Mary A. Jones		NAME OF CHILDREN John A. Jones		NAME OF SISTER Elizabeth A. Jones	
NAME OF BROTHER William A. Jones		NAME OF NEAREST RELATIVE Thomas A. Jones		NAME OF PHYSICIAN Dr. J. A. Smith	
NAME OF FUNERAL HOME Jones & Sons		NAME OF BURIAL PLACE St. Mary's Cemetery		NAME OF MINISTER Rev. J. A. Smith	

BUREAU V. 2

AUG 1 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

67700

7741 CERTIFICATE OF DEATH

Reg. Dist. No. 33✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Jesterville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jesterville</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jesterville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Edward James Heath</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 9 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-23-1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days <u>10 16</u>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward James Heath, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Julia Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS <u>Randall Heath, Jesterville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						4 years	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Trauma</u>						2 weeks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/14</u> , 19 <u>52</u> , to <u>7/9</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>7/9</u> , 19 <u>56</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Randall Saunders</u> M.D.				ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u>		DATE SIGNED <u>7/9/56</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		LOCATION (City, town, or county) <u>Jesterville, Maryland</u>	
24. REC'D BY REGISTRAR <u>JUL 13 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7742

CERTIFICATE OF DEATH

Reg. Dist. No. 332

07301

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) George Roy Hitch				4. DATE OF DEATH Month July Day 24 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1892		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman				10b. KIND OF BUSINESS OR INDUSTRY saleman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Hitch				14. MOTHER'S MAIDEN NAME Annie Clayville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) I				16. SOCIAL SECURITY NO. 214-10-6001		17. INFORMANT Address Mrs. George Hitch Nanticoke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/21 , 19 56 , to 7/24 , 19 56 , that I last saw the deceased alive on 7/24 , 19 56 , and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Saunders M.D.						DATE SIGNED 7/27/56	
PHYSICIAN'S NAME (Type) RICHARD H. SAUNDERS							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF July 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Parson Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley B. Wilson				ADDRESS Princess Anne, Maryland		24a. REC'D BY REGISTRAR DATE 7-31-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
Oct 1, 1956		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Farmer		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

AUG 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7719 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> Md. b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville Bishop</u> Rural			
				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>E.</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>7-</u> Day <u>29</u> Year <u>19 56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1891</u>	
				9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>chicken farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Josiah Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>155-03-0701</u>			
				17. INFORMANT <u>Ella Rayne Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral concussion: compound fracture of rt. tibia 9 hours</u> 812X DUE TO and fibula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked in front of oncoming car on Route #113</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> a.m. <u>7-</u> <u>28</u> <u>19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>RFD #113</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RFD #113</u>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-30-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u>				ADDRESS <u>Pocomoke City Md.</u>			
24a. REC'D BY REGISTRAR <u>8-1-56</u>				24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>			

NEW YORK STATE DEPARTMENT OF HEALTH—BALTHORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 2 1956
BUREAU V. B.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7743

CERTIFICATE OF DEATH

07703

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Allen</u>		<u>all her life</u>		TOWN <u>Allen (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Eden, Md Rt #2</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Betsy Ellen Jones</u>				<u>7 22 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FM</u>	<u>AA</u>	<u>Widowed</u>	<u>11-21-1878</u>	<u>78</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>At home</u>		<u>Allen, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Tull</u>				<u>(Unknown) Julia Tull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>None</u>		<u>Route # 2 Mrs Fannie Brewington, Eden, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422. IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>9 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Arterio-sclerotic cardio-vascular disease</u>						<u>years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-13-56</u> , 19....., to <u>7-22-56</u> , 19....., that I last saw the deceased alive on <u>7-22-56</u> , 19....., and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Emil L. Royen</u>				ADDRESS (Street, city, town, state) <u>407 Camden Ave. Salisbury, Md.</u>		DATE SIGNED <u>7-24-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-25-56</u>		<u>Friendship Cemetery</u>		<u>Allen, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE JUL 27 1956</u>		<u>Mary H. Holloway</u>		<u>Mary P. Stewart</u>		<u>J. F. Stewart Funeral Home, Salisbury, Md</u>	

CERTIFICATE OF DEATH

1956

3 33

NAME OF DECEASED ALICE M. BROWN		SEX F		DATE OF BIRTH 1-1-1898		PLACE OF BIRTH NEW YORK, N.Y.	
MARRIAGE MARRIED		OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		PLACE OF DEATH HOME	
DATE OF DEATH 7-27-1956		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH HOME		SIGNATURE OF PHYSICIAN J. J. BROWN	
SIGNATURE OF DECEASED ALICE M. BROWN		SIGNATURE OF WITNESS J. J. BROWN		SIGNATURE OF DECEASED ALICE M. BROWN		SIGNATURE OF WITNESS J. J. BROWN	

BUREAU V. S.

JUL 27 1956

RECEIVED

Handwritten signature

NOTARY PUBLIC

NOTARY PUBLIC
 My commission expires on the 1st day of January, 1957.
 I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health, State of Massachusetts.
 WITNESSETH my hand and the seal of my office this 27th day of July, 1956.
 [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07704

7744

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wetipquin				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wetipquin			
c. LENGTH OF STAY IN 1b Most of life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Quantico Rt. # 1				d. STREET ADDRESS Quantico Rt # 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Moley Last Joseph				4. DATE OF DEATH Month 7 Day 28 Year 19 56			
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife				10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Tyaskin, Wicomico Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Jones				14. MOTHER'S MAIDEN NAME Virginia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Foster Joseph, Quantico, Md. Rt. #1 Wetipquin				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from July 27, 1956 , to July 27, 1956 , that I last saw the deceased alive on July 27, 1956 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William E. Enrich M.D.				ADDRESS (Street, city or town, state) Helena Md DATE SIGNED July 29 56			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-56		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Wetipquin, Wicomico Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR 8-1-56		24b. REGISTRAR'S SIGNATURE Mary W. Hollaway	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH 1956	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF BURIAL OFFICIAL [Illegible]	
SIGNATURE OF FUNERAL HOME [Illegible]		SIGNATURE OF CEMETERY [Illegible]	
SIGNATURE OF CHURCH [Illegible]		SIGNATURE OF MINISTRY [Illegible]	
SIGNATURE OF OTHER [Illegible]		SIGNATURE OF OTHER [Illegible]	

BUREAU V. R.

AUG 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07705
7720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>North Park Gardens</u>	
3. NAME OF DECEASED (Type or print) First <u>De Forrest</u> Middle <u>August</u> Last <u>Laufer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cosmetics</u>	9. AGE (In years last birthday) <u>54</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willia Laufer</u>		14. MOTHER'S MAIDEN NAME <u>Macie Lentz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>196-07-5967</u>	
17. INFORMANT <u>Mrs F.A. Laufer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> <u>970.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2</u> hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Took bottle of sleeping pills.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took bottle of sleeping pills.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-28-19 56</u> Hour <u>7:30</u> a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		DATE SIGNED <u>7-31-56</u>	
22a. BURIAL, CREMATION, REMOVAL, ETC. <u>Cremation</u>		22b. DATE THEREOF <u>7/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wm Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co.</u>		ADDRESS <u>Salisbury, Maryland</u>	
24a. REC'D BY REGISTRAR <u>7-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>	

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



RECEIVED
AUG 2 1956
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7721

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>42 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Gray</u> Last <u>Lord</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4/1883</u>	
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Gray</u>				14. MOTHER'S MAIDEN NAME <u>Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca. of rectum</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>56</u> , to <u>July 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>56</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			
DATE SIGNED <u>7/18/56</u>							
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>20 JULY 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EAST NEW MARKET</u>		22d. LOCATION (City, town, or county) (State) <u>EAST NEW MARKET MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte FUNERAL SERVICE</u>				ADDRESS <u>CAMBRIDGE MD</u>		24a. REC'D BY REGISTRAR DATE <u>July 23, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Shilling</u>							

JUL 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7722

CERTIFICATE OF DEATH

07707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Putman</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palatka</u>			
c. LENGTH OF STAY IN 1b <u>4 hrs</u>				d. STREET ADDRESS <u>914 Main St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruby Lee Mack</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1955</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel Mack</u>		14. MOTHER'S MAIDEN NAME <u>Odessa Gilyard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Odessa Mack - 914 Main St, Palatka, Florida</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration, severe</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Gastroenteritis, acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>July 16, 1956</u> , to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>July 16, 1956</u> , and that death occurred at <u>2 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Saunderson, Jr.</u>				DATE SIGNED <u>7/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Saunderson, Jr.</u>				ADDRESS (Street, city or town, state) <u>926 N. Division St. Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>				ADDRESS <u>Funeral Home, Salisbury, Md.</u>			
24a. REC'D BY REGISTRAR <u>JUL 20 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

JUL 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18,7708 332
 7723 CERTIFICATE OF DEATH Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u> <u>19x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wessie</u> Middle <u>Anna</u> Last <u>Maddox</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1894</u>		9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No, Unk.</u>		16. SOCIAL SECURITY NO. <u>219-63-5887</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Ca. metastases of mediastinum and</u> <u>170x</u> DUE TO <u>spinal column</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca. of breasts</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>9 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8</u> , 19 <u>56</u> , to <u>July 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>56</u> , and that death occurred at <u>2:30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. W. Juerman</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>7/7/56</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/56</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Samuel Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Manokin, Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norma J. Ward - Marion Sta.</u>				ADDRESS <u>Marion Sta.</u>		24a. REC'D BY REGISTRAR DATE <u>7/11/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. J. G. [Signature]</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 5

JUL 16 1956

RECEIVED

7745

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1 Salisbury				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle FRANKLIN Last MATTHEWS				4. DATE OF DEATH Month 7 Day 2 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865 June 2, 1865		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Matthews				14. MOTHER'S MAIDEN NAME Jane Hosier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Rex Hill, R.F.D. #1 Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-15-56 , 19 56 , to 7-1-56 , 19 56 , that I last saw the deceased alive on 7-1-56 , 19 56 , and that death occurred at 6AM M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lu L Lawry M.D.				DATE SIGNED 7-2-56 ADDRESS (Street, city or town, state) Fruitland, Md.			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry, Fruitland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56		22c. NAME OF CEMETERY OR CREMATORY Union Church Cemetery		22d. LOCATION (City, town, or county) (State) Wicomico, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johns on Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR 7-5-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1911		Boston, Mass.		Natural		Heart Disease		Home		10:30 AM		J. Smith		A. Jones	
Occupation		Marital Status		Education		Religion		Usual Residence		Usual Occupation		Medical History		Previous Illnesses		Previous Operations		Previous Injuries		Previous Habits	
Teacher		Married		High School		Catholic		123 Main St.		Teacher		Hypertension		Angina Pectoris		None		None		Smoking	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Physician		Signature of Toxicologist		Signature of Chemist	
1956		10:30 AM		Home		J. Smith		A. Jones		B. Brown		C. Green		D. White		E. Black		F. Gray		G. Blue	

BUREAU V. 3

JUL 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07710

7724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 7 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill Route # 2 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Deer's Head State Hospital			
3. NAME OF DECEASED (Type or print) First Rutledge Middle McMunn Last McMunn				4. DATE OF DEATH Month July Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1894		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Rutledge McMunn			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent hemorrhage 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sq. Cell Carcinoma of left cheek with metastases DUE TO (c) 1 1/2 yrs						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 15 , 19 55 , to July 27 , 19 56 , that I last saw the deceased alive on July 27 , 19 56 , and that death occurred at 12 Noon , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE V. Juerman M.D.				Deer's Head State Hospital 7/27/56			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 30/56		Bates Methodist		Snow Hill, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Thomas, Snow Hill, Md				24a. REC'D BY REGISTRAR 15-30-1956		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1910		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1935		NEW YORK		NEW YORK		NEW YORK		JUL 30 1956		NEW YORK		NEW YORK	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		MORBIDITY		MORTALITY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		CORONARY ARTERY DISEASE		MYOCARDIAL INFARCTION		HYPERTENSION		DIABETES		JUL 30 1956		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JUL 30 1956		NEW YORK		NEW YORK		NEW YORK		JUL 30 1956		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JUL 30 1956		NEW YORK		NEW YORK		NEW YORK		JUL 30 1956		NEW YORK		NEW YORK		NEW YORK	

BUREAU V. 7

JUL 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07711

7725

Item 7, Film G200, 7/31/56 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LESTER Middle METCALF Last METCALF		4. DATE OF DEATH Month JULY Day 21 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) North Hampton Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Metcalf		14. MOTHER'S MAIDEN NAME Louise Savage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Francis Messick (Daughter)		Address Fruitland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7/21 , 19 56 to 7/21 , 19 56 , that I last saw the deceased alive on 7/21 , 19 56 , and that death occurred at 7:30P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas L. Jones, MD Ann Hill MD July 23 1956			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Thomas L. Jones, MD Ann Hill MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Bell Haven Cemetery
22d. LOCATION (City, town, or county) Bell Haven Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE FOX & JAMES FUNERAL HOME - EASTVILLE, VIRGINIA		24. REG'D BY REGISTRAR JUL 25 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		DATE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		COUNTRY [Faint text]	
AGE [Faint text]		SEX [Faint text]	
RACE [Faint text]		RELIGION [Faint text]	
MARRIAGE [Faint text]		OCCUPATION [Faint text]	
EDUCATION [Faint text]		MILITARY SERVICE [Faint text]	
PREVIOUS ILLNESS [Faint text]		CAUSE OF DEATH [Faint text]	
IMMEDIATE CAUSE [Faint text]		MEDICAL HISTORY [Faint text]	
HISTORICAL HISTORY [Faint text]		LABORATORY TESTS [Faint text]	
POST-MORTEM [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		DATE [Faint text]	

RECEIVED
JUL 25 1956
BUREAU V. S.

7746 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4, Film G200 7-19-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R F D		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marshall Middle Nevitt Last Milstead		4. DATE OF DEATH Month July Day 4 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1896
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Boating	
11. BIRTHPLACE (State or foreign country) Doncaster, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Milstead		14. MOTHER'S MAIDEN NAME Carrie Sanders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 706-12-2391	
17. INFORMANT Julia Milstead, Mardela, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease DUE TO (c) Years		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Notural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-56	
22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetary		22d. LOCATION (City, town, or county) (State) Mardela, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Gussul Co - Helmar Kell		24a. REC'D BY REGISTRAR DATE 12 1956	
		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		SIGNATURE OF EXAMINER _____	
ADDRESS OF DECEASED _____		SIGNATURE OF WITNESS _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

RECEIVED
 JUL 12 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07713

7726

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Rt #3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>Edward</u> Middle <u>Mitchell</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer owner</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr B. Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-36-2053</u>		17. INFORMANT Address <u>Bessie Mitchell Delmar Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22, 1956</u> , to <u>July 22, 1956</u> , that I last saw the deceased alive on <u>July 22, 1956</u> and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>July 22, 1956</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olives</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Salisbury Md</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

Handwritten entries on the certificate form, including names and dates, though largely illegible due to fading and bleed-through.

BUREAU V. 2

JUL 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7727 CERTIFICATE OF DEATH

07714

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 2/23/52</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>White Haven</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print) <u>Carlton Henry Moore</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>12</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 5, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Marion Station, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Moore</u>				14. MOTHER'S MAIDEN NAME <u>Sara E. Brittingham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-0240</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1941</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 23, 19 52</u> , to <u>July 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>56</u> , and that death occurred at <u>2:45</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>July 12, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>	DATE THEREOF <u>7/14/56</u>	NAME OF CEMETERY OR CREMATORY <u>Tyashin Cem.</u>		LOCATION (City, town or county) (State) <u>Tyashin, Md.</u>			
24. REC'D BY REGISTRAR <u>[Signature]</u>	REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u>		ADDRESS <u>Bivolve, Md.</u>			
DATE <u>July 7, 1956</u>							

CERTIFICATE OF DEATH

REC-333

DATE OF DEATH

John S. Smith

BUREAU V. S.

JUL 17 1956

RECEIVED

Handwritten signature and notes at the bottom of the page.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 4 Schumaker Pond		d. STREET ADDRESS R.D.# 4 Schumaker Road	
3. NAME OF DECEASED (Type or print) First ALBERT Middle EDWARD Last PARKER JR.		4. DATE OF DEATH Month JULY Day 2nd Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1940
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 4 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (School Boy)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pen. Gen. Hosp. Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Edward Parker		14. MOTHER'S MAIDEN NAME Martha Emma Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Albert E. Parker (Father)		Address R.D.# 4 Schumaker Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child swam beyond depth and sank.	
20c. TIME OF INJURY Month, Day, Year 5 P. M. 7- 2 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Schumaker Pond	20f. (City or town) (County) (State) Salisbury Wicomico Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME -SALISBURY, MD.		ADDRESS SALISBURY, MD.	
24a. REC'D BY REGISTRAR JUL 5 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUL 5 1956

7748

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville				c. LENGTH OF STAY IN 1b 45 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pittsville				d. STREET ADDRESS Pittsville			
3. NAME OF DECEASED (Type or print) ARTHUR HIRAM PARKER				4. DATE OF DEATH 7 1 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1879	9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan Parker				14. MOTHER'S MAIDEN NAME Annie Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Preston Parker, Salisbury Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury			
20c. TIME OF INJURY Month, Day, Year 19 56 Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat. while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, blog., etc.)	
20f. (City or town) Pittsville				20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I attended the deceased from 1953 , 19 7-1-56 , to day of death, that I last saw the deceased alive on 7-1-56 , 19 56 , and that death occurred at P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank R. Lewis M.D.				DATE SIGNED Willards Md.			
PHYSICIAN'S NAME (Type) Dr. Frank Lewis, Willards, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56		22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR 7-5-56		24b. REGISTRAR'S SIGNATURE Marjorie Holloway	

JUL 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7728 CERTIFICATE OF DEATH

07717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Salisbury Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dora B. Petry		4. DATE OF DEATH Month Day Year July 2 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY own home	9c. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	10c. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Murray		14. MOTHER'S MAIDEN NAME Mary Stakebake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT D. A. Petry		Address Selbyville, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1954, to July 2, 1956, that I last saw the deceased alive on July 2, 1956, and that death occurred at 8:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley		ADDRESS (Street, city or town, state) Selbyville, Del.	
PHYSICIAN'S NAME (Type) Philip A. Insley		DATE SIGNED 7-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56	
22c. NAME OF CEMETERY OR CREMATORY Red Men		22d. LOCATION (City, town, or county) (State) Selbyville Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24. REC'D BY REGISTRAR Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07718

7729

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBACKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>LAWRENCE, JAS. PORTER</u>				4. DATE OF DEATH <u>JULY 25 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 19 1891</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR <u>10</u> Months <u>3</u> Days		IF UNDER 24 HRS. <u>5</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>MILBY PORTER</u>				14. MOTHER'S MAIDEN NAME <u>CORA STURGIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. L. J. Porter</u>		Address <u>Greenbackville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerulonephritis</u> DUE TO <u>Chronic Glomerulonephritis</u> (c) <u>Chronic Glomerulonephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>56</u> , to <u>July 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>56</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Mary W. Holloway</u> M.D.				DATE SIGNED <u>July 25, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 27</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FRANKLIN</u>		22d. LOCATION (City, town, or county) (State) <u>FRANKLIN City VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. T. A. Shields</u>				ADDRESS <u>New Church Va</u>		24a. REC'D BY REGISTRAR <u>7-27-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7730

CERTIFICATE OF DEATH

Reg. Dist. No.

0771832

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>SOMERSET.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> <u>19X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RENA</u> Middle <u>POWELL</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 11, 1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Edward Dougherty</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Norris Hancock Princess Anne Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-10</u> , 19 <u>56</u> , to <u>7-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-10</u> , 19 <u>56</u> , and that death occurred at <u>11:59 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>7-11-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/13/56</u>		<u>St Peters</u>		<u>Hopewell</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Simon</u>				ADDRESS <u>Princess Anne Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-14-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

BUREAU V. S.

JUL 17 1956

RECEIVED

7731

CERTIFICATE OF DEATH

Reg. No. 21

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 618 Smith St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NORMAN Middle LEROY Last PRETTYMAN				4. DATE OF DEATH Month JULY Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 1 Days 7	IF UNDER 24 HRS. Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Checker) Victor Lynn Lines			10b. KIND OF BUSINESS OR INDUSTRY Sussex County, Delaware		11. BIRTHPLACE (State or foreign country) U S A		
13. FATHER'S NAME Robert Prettyman				14. MOTHER'S MAIDEN NAME Doris Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Irene E. Prettyman (Wife) Address 618 Smith St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma to brain 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma (c) Bronchogenic Carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/24 , 19 56 , to 7/26 , 19 56 , that I last saw the deceased alive on 7/26 , 19 56 , and that death occurred at 12:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St. (Peninsula Medical Bldg.) DATE SIGNED July 27 1956							
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. M.D. Salisbury, Maryland July 27 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 30 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		50		JAN 15 1885	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTERED	
JUL 20 1956		BALTIMORE		12345		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUL 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **077232**

7732

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 W. Philadelphia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Relien Last Rankin		4. DATE OF DEATH Month 7- Day 31 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1891
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Reilein		14. MOTHER'S MAIDEN NAME Barbara Urf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT S. F. Rankin, Same address.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell dead while ironing in home.	
20c. TIME OF INJURY Month, Day, Year Hour 1:45 P.M. 7-31-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 8-1-56	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-56	
22c. NAME OF CEMETERY OR CREMATORY Elmlawn Cemetery		22d. LOCATION (City, town, or county) (State) Kenmore, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Hill and Johnson Co. Salisbury, Md.		24a. REC'D BY REGISTRAR Norman Baker	
24b. REGISTRAR'S SIGNATURE Mary W. Hollman		DATE 8-2-56	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

AUG 3 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07722

7749

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>White Haven</u>		<u>13 Yrs.</u>		TOWN <u>White Haven</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lawrence J. Robertson</u>				<u>July 1 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11-25-1878</u>	<u>77</u> yrs.	Months <u>7</u>	Days <u>6</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Dentist</u>		<u>D.D.S.</u>		<u>Nanticoke, Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elias Robertson</u>				<u>Mary Ellen Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>-----</u>		<u>Lucy J. Robertson, White Haven, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
155X IMMEDIATE CAUSE (A)				<u>Carcinoma Bile Ducts.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Fracture.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>6 months</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/14</u> , 19 <u>51</u> , to <u>7/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/1</u> , 19 <u>56</u> , and that death occurred at <u>8:50</u> A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>William H. Saunders M.D.</u>				<u>7/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE-THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-8-56</u>		<u>Tyaskin Cemetery</u>		<u>Tyaskin, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>9 1956</u>		<u>Mary H. Holloway</u>		<u>C. L. Messier</u>		<u>Bivalve, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 JPM

CERTIFICATE OF DEATH

Reg. No. 111

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. PREVIOUS ILLNESS

15. PRESENT ILLNESS

16. MEDICAL ATTENDANCE

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESSES

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF CLERK

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CORONER

26. SIGNATURE OF DISTRICT ATTORNEY

27. SIGNATURE OF COUNTY CLERK

28. SIGNATURE OF TOWNSHIP CLERK

29. SIGNATURE OF VILLAGE CLERK

30. SIGNATURE OF CITY CLERK

31. SIGNATURE OF STATE CLERK

32. SIGNATURE OF FEDERAL CLERK

33. SIGNATURE OF MARSHAL

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF JURY

36. SIGNATURE OF JUDGE

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF CORONER

39. SIGNATURE OF DISTRICT ATTORNEY

40. SIGNATURE OF COUNTY CLERK

41. SIGNATURE OF TOWNSHIP CLERK

42. SIGNATURE OF VILLAGE CLERK

43. SIGNATURE OF CITY CLERK

44. SIGNATURE OF STATE CLERK

45. SIGNATURE OF FEDERAL CLERK

46. SIGNATURE OF MARSHAL

47. SIGNATURE OF SHERIFF

48. SIGNATURE OF JURY

49. SIGNATURE OF JUDGE

50. SIGNATURE OF SHERIFF

51. SIGNATURE OF CORONER

52. SIGNATURE OF DISTRICT ATTORNEY

53. SIGNATURE OF COUNTY CLERK

54. SIGNATURE OF TOWNSHIP CLERK

55. SIGNATURE OF VILLAGE CLERK

56. SIGNATURE OF CITY CLERK

57. SIGNATURE OF STATE CLERK

58. SIGNATURE OF FEDERAL CLERK

59. SIGNATURE OF MARSHAL

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF JURY

62. SIGNATURE OF JUDGE

63. SIGNATURE OF SHERIFF

64. SIGNATURE OF CORONER

65. SIGNATURE OF DISTRICT ATTORNEY

66. SIGNATURE OF COUNTY CLERK

67. SIGNATURE OF TOWNSHIP CLERK

68. SIGNATURE OF VILLAGE CLERK

69. SIGNATURE OF CITY CLERK

70. SIGNATURE OF STATE CLERK

71. SIGNATURE OF FEDERAL CLERK

72. SIGNATURE OF MARSHAL

73. SIGNATURE OF SHERIFF

74. SIGNATURE OF JURY

75. SIGNATURE OF JUDGE

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF CORONER

78. SIGNATURE OF DISTRICT ATTORNEY

79. SIGNATURE OF COUNTY CLERK

80. SIGNATURE OF TOWNSHIP CLERK

81. SIGNATURE OF VILLAGE CLERK

82. SIGNATURE OF CITY CLERK

83. SIGNATURE OF STATE CLERK

84. SIGNATURE OF FEDERAL CLERK

85. SIGNATURE OF MARSHAL

86. SIGNATURE OF SHERIFF

87. SIGNATURE OF JURY

88. SIGNATURE OF JUDGE

89. SIGNATURE OF SHERIFF

90. SIGNATURE OF CORONER

91. SIGNATURE OF DISTRICT ATTORNEY

92. SIGNATURE OF COUNTY CLERK

93. SIGNATURE OF TOWNSHIP CLERK

94. SIGNATURE OF VILLAGE CLERK

95. SIGNATURE OF CITY CLERK

96. SIGNATURE OF STATE CLERK

97. SIGNATURE OF FEDERAL CLERK

98. SIGNATURE OF MARSHAL

99. SIGNATURE OF SHERIFF

100. SIGNATURE OF JURY

BUREAU V. E.

JUL 9 1956

RECEIVED

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7733

CERTIFICATE OF DEATH

07724

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pottstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS R.D.# 18 1494 Hilltop Road	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last STANFORD		4. DATE OF DEATH Month JULY Day 14 Year th 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1874
9. AGE (In years lost birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Butcher	
10b. KIND OF BUSINESS OR INDUSTRY Owned Meat Store		11. BIRTHPLACE (State or foreign country) R.D.# Snow Hill, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James Edward Stanford	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Bowden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Francis Wagg (Daughter) R.D.#18 / 1494 Hill Top Road - Pottstown, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David J. Gilmore M.D.		DATE SIGNED July 14, 1956	
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore M.D.		Medical Bldg. Salisbury, Maryland 7/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 16 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

BUREAU V. S.

JUL 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7753

CERTIFICATE OF DEATH

Reg. Dist. No.

187725
337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 4		d. STREET ADDRESS R.D.# 4	
3. NAME OF DECEASED (Type or print) First DANIEL Middle JAMES Last TILGHMAN		4. DATE OF DEATH Month JULY Day 13 Year th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) R.D.# 4 Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noah Lemon Tilghman		14. MOTHER'S MAIDEN NAME Louisa Matthews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. H. Oliver Tilghman (Son)		Address R.D.# 4 Salisbury Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1956 , to July 13, 1956 , that I last saw the deceased alive on July 10, 1956 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 116 East Main St. (Office) July 13 1956			
ACTUAL SIGNATURE Philip A. Insley		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 106 16 1956	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary N. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7734

CERTIFICATE OF DEATH

Reg. Dist. No. 07336

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 1/2 Wks.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Camden Court, 612 Smith St.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>CINDERELLA</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1956</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Mathias Disharoom</u>			14. MOTHER'S MAIDEN NAME <u>Ella Hayman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>George R. Turner Sr., Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u> </u> (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that I attended the deceased from <u>1/15/55</u> , 19 <u>55</u> , to <u>7/17/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/13/56</u> , 19 <u>56</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Dr. Andrew C. Mitchell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell . 211 Maryland Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>		(State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u> <u>Norman T. Baker</u>			24a. REC'D BY REGISTRAR DATE <u>7-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07727

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 1 year		d. STREET ADDRESS 717 Rose St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Preston Middle Watkins Last Watkins		4. DATE OF DEATH Month 7- Day 27 Year 19 56	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1930
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY H. D. Metal Co.	
11. BIRTHPLACE (State or foreign country) Ansonville, N.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Paul Watkins		14. MOTHER'S MAIDEN NAME Bertha Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 245-44-4530	
17. INFORMANT Mother Mrs. Bertha Watkins		Address Wadesboro, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to bullet wound of aorta DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO 981x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in fight with another man.	
20c. TIME OF INJURY Hour 9 P a. m. 7-27- 19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED 7-30-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-30-56	
22c. NAME OF CEMETERY OR CREMATORY City Hill Cemetery		22d. LOCATION (City, town, or county) (State) Wadesboro, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE 8-1-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

BUREAU V. 3

AUG 1 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07728

7736

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 20 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 North Division St.,				d. STREET ADDRESS 319 North Division St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK		First W. C.		Middle W. C.		Last WEBB	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month 7 Day 4 Year 1956	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Cooperation		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W.T. Webb		14. MOTHER'S MAIDEN NAME Anna Virginia Conway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret S. Webb, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7-5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11-2-53 , 19____, to 7-4 , 19 56 , that I last saw the deceased alive on 7-3 , 19 56 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Briele		M.D. Medical Center		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 7-6-56	
PHYSICIAN'S NAME (Type) Dr. Henry Briele		Medical Center Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/56		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland Normant Boken				24a. REC'D BY REGISTRAR DATE 7-6-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

1956 6 706

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS Glen St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HOWARD Middle ROLAND Last WELLS				4. DATE OF DEATH Month July Day 16 Year 19 56									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1908		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 3 Days 2		IF UNDER 24 HRS. Hours 8 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installed Gas Pumps for Oil Companies				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Service Station Repair-man Leet Cannon Wells						14. MOTHER'S MAIDEN NAME Florence Parsons							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Beatrice Nellie Wells (Wife) Glen St. Salisbury, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of the brain DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound.									
20c. TIME OF INJURY Month, Day, Year Hour 10 A. a. m. 7-16-56 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home-garage.		20f. (City or town) Salisbury (County) Wicomico (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Earl B. Royer</i> Dr. Earl B. Royer M.D.						DATE SIGNED July 17 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 21 1956		22c. NAME OF CEMETERY OR CREMATORY Farlow Cemetery		22d. LOCATION (City, town, or county) (State) Near Pittsville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.						24a. REC'D BY REGISTRAR DATE 23 1956		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		Male		45		White		April 15, 1956		Home		Heart Disease		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 JUL 23 1956
 BUREAU V. S.